

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gary Lines a prisoner at HMP Northumberland on 18 September 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Gary Lines was found hanged in his cell at HMP Northumberland on 18 September 2015. He was 44 years old. I offer my condolences to Mr Lines' family and friends.

Prison staff had begun suicide and self-harm prevention procedures when Mr Lines harmed himself on 13 September, but case reviews were not multidisciplinary and healthcare staff were not involved. No one checked Mr Lines' community prescription from the time he arrived in prison on 8 August and he was not prescribed antidepressants, which he said he needed to help drive off suicidal thoughts, until the day before he died.

While I consider it would have been difficult to predict that Mr Lines was at high and imminent risk of suicide, I am concerned that a lack of effective information sharing and consideration of his risk factors led to his risk being underestimated and a low level of observations. On the morning he was found hanged, I am not satisfied that staff checked Mr Lines' wellbeing effectively.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

July 2016

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Summary

Events

1. Mr Gary Lines was released from prison on licence in June 2015. On 8 August, he was recalled to HMP Durham. A nurse recorded that he had a history of depression, self-harm and drug misuse. He was prescribed methadone to treat heroin withdrawal. Mr Lines said that he had been prescribed antidepressants but no one checked this with his community GP. On 11 August, he was referred Mr Lines to the mental health team, but no one from the team saw him while he was at Durham. During his time at Durham, no one assessed him as at risk of suicide and self-harm.
2. On 3 September, Mr Lines moved to Northumberland. A nurse recorded he had a history of depression, drug use and self-harm, and referred him to the mental health team. She did not consider he was a risk of suicide and self-harm. A few days later, he said he felt settled. Against a nurse's advice, he decided to stop taking methadone.
3. On the night of 13 September, Mr Lines cut his arm and said that this was because he had still not received his antidepressants. Staff began Prison Service suicide and self-harm prevention measures known as ACCT. On 14 September, a senior officer did not invite healthcare staff to attend the first ACCT case review and held it on his own.
4. On 17 September, a prison GP prescribed an antidepressant. An ACCT case review later that day, again without a member of healthcare staff present, assessed his risk as low and reduced the level of staff observations to three during the night, with three recorded conversations with Mr Lines during the day.
5. The night patrol officer said that Mr Lines was in bed at 6.52am on 18 September, but he did not record this at the time. At 7.53am on 18 September, an officer checked Mr Lines but was not sure whether he had responded. The officer looked into his cell again at 9.00am and thought he was standing at the window, as he had been over an hour earlier. Mr Lines did not respond when he spoke to him and the officer went back at 9.06am. He went into the cell and found that Mr Lines had hanged himself by a shoelace attached to the window. He radioed an emergency and a nurse responded quickly. It was evident that Mr Lines had been dead for some time so the staff did not try to resuscitate him. At 9.25am, a prison GP certified Mr Lines' death.

Findings

6. Although Mr Lines reported that he had been prescribed antidepressants when he was recalled to prison, no one checked his prescription with his community GP. He was not prescribed antidepressants until the nearly six weeks later, the day before he died, and never received them. Staff did not use ACCT procedures effectively to support him. There was no healthcare involvement in ACCT case reviews and no other multidisciplinary representation. Ineffective consideration of his risk factors, led to his risk of suicide being underestimated.

However, we accept that there was little to indicate that Mr Lines was at imminent and high risk of suicide immediately before he died.

7. It appears that Mr Lines had been dead for some time when he was found hanged and we are satisfied that staff acted appropriately when they did not try to resuscitate him. However, we are concerned that the staff who checked Mr Lines' welfare on the morning he died did not establish he was alive and breathing, as they should have done.

Recommendations

- The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including a multidisciplinary approach for all case reviews, with healthcare staff attending at least all first case reviews. Case reviews should assess the risk of suicide or self-harm based on all available information and set level of observations which reflect that risk.
- The Heads of Healthcare at Durham and Northumberland should ensure that staff request and obtain community GP records in accordance with PSO 3050 to help effective continuity of healthcare.
- The Director should ensure that staff obtain a response from prisoners if they cannot establish that the prisoner is alive and breathing during roll checks, welfare checks, or ACCT checks.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. NHS England commissioned a clinical reviewer to review Mr Lines' clinical care at the prison.
10. The investigator visited Northumberland between 19 and 27 October 2015. He obtained copies of relevant extracts from Mr Lines' prison and medical records. He interviewed ten members of staff at Northumberland, some jointly with the clinical reviewer.
11. We informed HM Coroner for Northumberland of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Lines' uncle to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Lines' uncle asked us to clarify whether Mr Lines had received appropriate help for his mental health problems and whether he had received his prescription medication appropriately.
13. Mr Lines' family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Northumberland

14. HMP Northumberland is a medium security prison operated by Sodexo, predominantly holding prisoners from the North East. The prison holds up to 1300 men. As of 1 April 2015, G4S provides healthcare services prior to this it was provided by Care UK.

HM Inspectorate of Prisons

15. In the report of the most recent inspection of Northumberland in September 2014, inspectors noted that reception arrangements were too process-driven and little was done to reassure anxious new arrivals. Not all had first night risk assessments. New arrivals usually received a health screen but were not systematically followed up for a full health assessment. There had been three self-inflicted deaths at the prison since the last inspection in 2012. Previous monitoring of the implementation of the Prisons and Probation Ombudsman's recommendations into deaths at the prison had lapsed. The number of prisoners assessed as at risk of suicide or self-harm and being monitored under ACCT procedures was relatively low. Inspectors found the quality of care they received was good. Mental health services were also good.

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to December 2014, the IMB noted that attendance at ACCT reviews by staff from relevant agencies, particularly the mental health team, had improved. However, the IMB remained concerned that primary healthcare staff were often unable to attend.

Previous deaths at HMP Northumberland

17. Mr Lines' death was the first self-inflicted death at Northumberland since 2014. We have previously identified the need for ACCT case reviews to be multidisciplinary.

Assessment, Care in Custody and Teamwork

18. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

19. On 19 June 2015, Mr Gary Lines was released on licence from HMP Durham. He did not have fixed accommodation in the community. He had a long history of drug use, and had previously harmed himself in the community and in prison.
20. On 8 August, Mr Lines was charged with theft and recalled to prison. His alleged offences were against a vulnerable woman he described as a mother figure. Mr Lines had a history of targeting vulnerable people, and his recall was regarded as necessary to protect the public.
21. His offender manager (probation officer) said that Mr Lines often did not comply with supervision and had a pattern of being released from prison, returning to drug use, offending, and returning to prison, where he would stop using drugs. She said that at their last supervision session, Mr Lines had shown her a burn on his thumb, which he had caused with a lighter. He said he had thoughts of suicide but did not want to engage with mental health teams in the community.

HMP Durham

22. At an initial health screen at HMP Durham on Saturday 8 August, a nurse recorded that Mr Lines said that he used heroin each day and had made cuts to his arm four days earlier. This information was also on a self-harm warning form received from the court. Mr Lines said that he had last tried to harm himself in prison a few years before when he had swallowed batteries.
23. Mr Lines said that he had been prescribed mirtazapine for depression in the community. No one requested Mr Lines' community GP records to check his prescription. The nurse referred Mr Lines to the GP because of his substance misuse. He told the investigator that he did not think that a referral to the mental health team was necessary. The nurse signed the self-harm warning form from court and noted that he did not consider that Mr Lines needed to be monitored under ACCT suicide and self-harm prevention procedures. Mr Lines tested positive for opiates.
24. A prison GP saw Mr Lines after his health screen. He noted that Mr Lines said he used £30 worth of heroin daily but no other drugs or alcohol. He did not have any clinical signs of opiate withdrawal. He told Mr Lines that the drug and alcohol rehabilitation team (DART) would observe him and review him after the weekend. He did not record Mr Lines' history of self-harm or depression. There is no record that Mr Lines mentioned his antidepressants, and he was not prescribed them at Durham.
25. On 10 August, a prison GP reviewed Mr Lines and noted his heroin use. Mr Lines said he had previously been prescribed 30mg of methadone in prison and had self-harmed a week earlier in the community, as he had been desperate for help at the time. Mr Lines said he had no current thoughts of suicide or self-harm. The GP prescribed a methadone maintenance programme for Mr Lines.
26. On the evening of 10 August, a prison GP reviewed Mr Lines and noted that the wound on Mr Lines' forearm was inflamed so he prescribed antibiotics. Mr Lines said he had no current thoughts of harming himself. He encouraged him to

report any thoughts of self-harm or low mood to staff. He told the investigator that Mr Lines did not show any signs of mental health problems when he saw him.

27. On 11 August, a healthcare support worker recorded that Mr Lines' self-harm warning form had been added to his medical record and referred Mr Lines to the primary care mental health team for an assessment. This is standard practice at Durham when a prisoner arrives with a self-harm warning form. The substance misuse team monitored Mr Lines each day until 17 August for symptoms of opiate withdrawal and reviewed his level of methadone each week.
28. Mr Lines received his recall papers shortly after he arrived at Durham, which said he would remain in prison at least until his licence expired in February 2016, depending on the outcome of the criminal investigation.

HMP Northumberland

29. On 3 September, Mr Lines moved to HMP Northumberland. Someone from the mental health team and someone from the DART substance misuse team spoke to staff at Northumberland to hand over his care. The member of the mental health team said that he should have had a routine mental health assessment, but they had not been able to do one before his transfer.
30. On 4 September, a nurse saw Mr Lines at Northumberland and recorded his history of depression and previous self-harm. She referred him to the mental health team and the DART. Mr Lines said he did not have any thoughts of suicide and self-harm. He asked to see a GP, as he wanted to start taking mirtazapine again.
31. On 6 September, a nurse saw Mr Lines to give him methadone but he said that he no longer needed it. She recorded that she tried to persuade him to continue to take it because of the possibility of withdrawal symptoms. However, Mr Lines said that he usually stopped taking methadone in prison, once he was settled. She told the DART about his decision.
32. The next day, the DART clinical team manager went to see Mr Lines to discuss his decision. He told her that he had done this many times before. He said that, although he used heroin in the community, he took the opportunity to come off drugs when he was in prison.
33. The DART clinical team manager said that Mr Lines was relaxed and open with her. They spoke about his decision-making, goal-setting, and his support networks. He said he wanted to stay in the local area so that his children could contact him if they wanted. She said that she had specifically asked Mr Lines how he felt because he had showed her his old self-harm injuries. He told her he felt fine. She said that Mr Lines did not appear to have mental health problems and she did not consider that he was at risk of suicide or self-harm.
34. At 9.40pm on 13 September, the night patrol officer answered Mr Lines' cell call bell. Mr Lines had made some superficial cuts to his left arm and told the officer that he was stressed but did not say why. The officer informed the night manager. Mr Lines said that he felt all right and had no thoughts of further self-harm. Staff removed razor blades from his cell, began ACCT suicide and self-harm prevention procedures and dressed the wound. Mr Lines then said that he

had been stressed about his medication, which had caused him to self-harm. The officer observed Mr Lines at least once an hour for the rest of the night.

35. The next morning, 14 September, a nurse treated the wound. She said she could not recall Mr Lines telling her why he had cut himself but said he did not appear very anxious and she did not think he had mentioned medication. She said that she had discussed ways of dealing with stress.
36. Later that morning, an officer assessed Mr Lines as part of ACCT procedures. He recorded that Mr Lines' only issue was his antidepressant medication. Mr Lines said that taking antidepressants reduced the frequency of his suicidal thoughts but he had not received any since it had been stopped at Durham. He said that suicidal thoughts had overpowered him the previous night and he had cut himself to help cope with the thoughts. He said this was his usual method of coping. Mr Lines told the officer that he had had feelings of wanting to kill himself since he was a child, and had sometimes attempted this. He said he had little contact with his family, and had had no permanent accommodation since 1996. He said he wanted to see someone from the mental health team (as he had done when he was previously at Northumberland), he wanted someone to review his medication, and would like a prison job. The officer recorded that he did not consider Mr Lines a risk of immediate self-harm, as he had said he did not intend to kill himself.
37. The officer told the investigator that Mr Lines had said that he had asked to see the GP about his medication. He could not recall whether he had checked whether the appointment had been made. He said that, in hindsight, he should have made it clearer in his assessment that the GP appointment was important and that Mr Lines' risk could increase if the appointment went badly or he did not get the medication he wanted. He could not recall whether he spoken to the manager holding the case review about his assessment.
38. After the officer's assessment, a senior prison custody officer held the first case ACCT case review with Mr Lines but no other member of staff was present, although it is a mandatory requirement that ACCT case reviews should be multidisciplinary and a member of healthcare staff should attend at least the first case review. He recorded that Mr Lines was upbeat and felt much better. His wounds had been dressed and Mr Lines said he had cut himself as a way of release. He recorded Mr Lines' main issues were medication (which he believed was about methadone) and getting a job. These issues were added to the caremap. He said that Mr Lines had applied for a prison job and had a GP appointment booked. He assessed that Mr Lines was low risk of further self-harm, and asked staff to check him four times during the day and five times at night. He set the next case review for 18 September.
39. At 11.10am on 17 September, Mr Lines had an appointment with a locum GP and told her that Durham had stopped his antidepressant medication (mirtazapine) when he arrived there on 8 August. Mr Lines told her that he had had a long-standing prescription ever since his previous sentence at HMP Woodhill, and had seen a nurse for talking therapies when he was previously at Northumberland. She noted that he had been referred for a mental health assessment. She prescribed citalopram, an antidepressant, and asked nurses to

chase up Mr Lines' medication history as she could not see any reference to mirtazapine on his medical record. She told the clinical reviewer that Mr Lines did not appear obviously depressed. He maintained good eye contact, his mood appeared stable, and he raised no significant concerns with her. He did not have any obvious signs of withdrawing from methadone.

40. At 2.30pm on 17 September, a senior prison custody officer and an officer held another ACCT case review. The senior prison custody officer told the investigator that he had phoned the mental health team before the review but did not get a reply. He recorded that Mr Lines engaged positively during the review, but he still had to resolve medication and mental health issues. He noted that Mr Lines seemed upbeat and focussed on the future. The review assessed his risk of suicide and self-harm as low and reduced the level of observations to one recorded conversation with Mr Lines in the morning, afternoon and evening, and three checks during the night.
41. The senior prison custody officer told the investigator that Mr Lines has said he was looking forward to his release. He said they had discussed his housing problems and help he could get from the housing charity, Shelter. He recalled that the officer was going to give Mr Lines more information about this, but he did not add this as a caremap action. He said that he decided to continue ACCT monitoring, as he did not know Mr Lines, and they had not yet resolved issues such as his accommodation after release, a job in the prison and contact with the mental health team.
42. That night, the night patrol officer on Mr Lines' wing checked Mr Lines at 9.19pm, 10.32pm, 11.55am, 5.59am, and 6.52am. After the last check at 6.52am, he summarised his checks for the night as a handover for the day staff and recorded that Mr Lines had watched television for a while but had then gone to sleep quite early. Although he did not record this in the ACCT document, he told the investigator that he was certain that Mr Lines had been in bed at the time of his last check at 6.52am.
43. At 7.53am on 18 September, Officer A checked Mr Lines. He described this as a welfare check, which would require a visual check and a verbal response from the prisoner. He told the investigator that he thought that Mr Lines had said something to him. He could not recall what, but said he would not have moved on if he had not responded. He said that he had checked over 50 prisoners that morning and it was a noisy environment. He said that Mr Lines was standing in a 'totally natural position' looking out of his cell window but he could not recall seeing him move.
44. At around 9.00am, Officer A went to Mr Lines' landing to unlock a prisoner for an appointment but some prisoner cleaners asked him to speak to the prisoner in the cell next to Mr Lines. He could not remember what the prisoner said but he thought he had some concerns about Mr Lines and it prompted him to check Mr Lines again. He said that when he looked through the door observation panel, Mr Lines was standing straight, fully clothed with his hands in a raised position on either side of the window and looked very much alive. He did not try to get a response from him and he did not turn to see who was looking in the cell. He said he did not notice that there was anything wrong but decided he would go

back to Mr Lines later to speak to him, as he needed to record a conversation with him as part of the ACCT monitoring.

45. Officer A unlocked the prisoner he had come to let out for an appointment and then went back to Mr Lines' cell. He looked through the observation panel and saw Mr Lines still standing at the window looking out. He said he opened the cell door and started talking to Mr Lines and was puzzled when he did not reply. He began to feel that something was not right, as Mr Lines did not move.
46. As Officer A approached Mr Lines, he touched his arm which was discoloured, stiff and cold. He then noticed a shoelace around Mr Lines' neck attached to the window. He cut the shoelace from the window and Mr Lines remained in the same position, standing up. He then rested Mr Lines against the bed, before removing the ligature from around his neck. Mr Lines was rigid and cold and his body remained in the same position. He then radioed a code blue medical emergency.
47. Two officers responded to the code blue and, when they arrived at Mr Lines' cell, said Mr Lines was lying half on, half off the bed. He looked grey and his eyes were open. Officer B thought that Mr Lines was dead and asked Officer A to leave the cell as he was in shock.
48. A nurse was in the healthcare unit when she heard the emergency call and responded immediately. She said that it took her only a few minutes to reach Mr Lines' cell. She assessed Mr Lines but found no signs of life; his pupils were fixed, his skin was mottled, and there were clear indications of rigor mortis. She was sure that Mr Lines was dead and therefore did not try to resuscitate him. A GP was holding a clinic when she heard the emergency medical call and nurses told her that she did not need to respond. Shortly afterwards, a nurse asked her go to Mr Lines cell and she noted he had advanced rigor mortis. At 9.25am, she confirmed his death.
49. Control room staff had called an ambulance when Officer A radioed the code blue. The GP met the paramedics arriving when she left the wing and told them that she had already confirmed Mr Lines' death. The paramedics therefore did not go onto the wing.
50. Mr Lines had left a note in his cell in which he said that he was very sorry to all the people he had hurt in his life.

Contact with Mr Lines' family

51. The prison appointed a senior prison custody officer and an officer to liaise with Mr Lines' family. Mr Lines had not given the prison any next of kin details when he arrived. During ACCT reviews he said he did not have any contacts outside prison. The senior prison custody officer spoke to the police, social services, and staff at the hostel where Mr Lines had lived before he was recalled, but was unable to trace any next of kin.
52. On 18 September, the senior prison custody officer decided to contact a former partner of Mr Lines who was named in probation records, but she did not want to be involved. On 21 September, the Probation Service found an address for Mr Lines' uncle. Both family liaison officers visited him that day and told him that Mr

Lines had died. The prison paid funeral expenses, in line with national instructions.

Support for prisoners and staff

53. After Mr Lines' death, a manager debriefed the staff involved in the emergency response and offered support and that of the staff care team.
54. The prison posted notices informing other prisoners of Mr Lines' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Lines' death. The prison later held a memorial service for him

Post-mortem report

55. A post-mortem examination found that Mr Lines had died of pressure on the neck caused by hanging. The pathologist noted extensive hypostasis (pooling of the blood) in his lower limbs, which indicated that it was likely that Mr Lines had been dead for several hours before his body was moved from the upright position.

Findings

Management of the risk of suicide

56. Mr Lines had a number of risk factors for suicide when he arrived at Durham on 8 August. He had been recalled to prison, had a history of substance misuse and had previously harmed himself in the community and in prison. He arrived with a self-harm warning form completed at court and had self-harmed by cutting his arm just four days earlier. He tested positive for opiates. He had no permanent home and no external support. Prison staff were aware of this information but did not consider that he was at raised risk, such that he needed monitoring under ACCT suicide and self-harm prevention procedures. While we might have expected staff at Durham to begin ACCT monitoring, we accept that the staff were aware of his risk factors and took them into account, when reaching their decision.
57. Staff at Northumberland began to monitor Mr Lines under ACCT procedures on the evening of 13 September after he made, what were described as superficial cuts to his arm. We are concerned that the ACCT procedures were not fully consistent with Prison Service instructions.
58. On 14 September, Mr Lines told an officer at an ACCT assessment that he had constant suicidal thoughts and was concerned that he was not getting his medication, which helped him cope with the thoughts. He said he had previously tried to kill himself. Prison Service Instruction (PSI) 64/2011 has a mandatory instruction that the ACCT assessor should attend the first ACCT case review if possible and if they cannot attend “they must meet with the Residential/Case Manager prior to the first case review and give a detailed summary of the assessment discussions and key issues”. The officer did not attend the case review held immediately after the assessment and could not remember speaking to the officer who held the first case review. It is therefore not clear how well the information at the ACCT assessment interview was passed on.
59. PSI 64/2011 expects case reviews to be multidisciplinary where possible and there is a mandatory requirement that healthcare staff must attend the first case review. Another officer held the case review alone, which is poor practice and contrary to the instructions in the PSI. Even when multidisciplinary attendance is not possible, it is implicit that ACCT reviews, which are based on teamwork, involve more than one member of staff. One of Mr Lines’ main issues was his medication and we are concerned that this issue could not have been considered appropriately without healthcare staff attending. There was no member of healthcare present at the second case review and, although a wing officer was there, this was not multidisciplinary.
60. Mr Lines had self-harmed just the night before the first case review and had told an officer that he had overpowering thoughts of suicide and needed medication to prevent them. However, at the review another officer, acting alone, assessed Mr Lines’ risk of suicide and self-harm as low. We consider that guidance contained in ACCT documents would indicate that his risk should have been regarded as raised. On 17 September, at the second review, little had changed. Mr Lines’ risk was still assessed as low and his observations were reduced so that only three checks were required during the night.

61. Although we consider it would have been difficult for staff to have identified that Mr Lines was at very high and imminent risk of suicide on 17 September, we are concerned about the lack of multidisciplinary involvement in case reviews, that not all relevant information was considered and that this hindered effective assessment of Mr Lines' risk. We make the following recommendation:

The Director should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidance, including a multidisciplinary approach for all case reviews, with healthcare staff attending at least all first case reviews. Case reviews should assess the risk of suicide or self-harm based on all available information and set level of observations which reflect that risk.

Clinical care

62. The clinical reviewer said that, overall, the care Mr Lines received at Northumberland was equivalent to the care he would have received in the community.
63. However, when Mr Lines arrived at Durham, he said that he had been prescribed mirtazapine in the community. There is no evidence that anyone checked this. Prison Service Order 3050, which covers continuity of healthcare, requires healthcare staff to make efforts to obtain information from a prisoner's GP or any other relevant service with which he has had recent contact. No one requested Mr Lines' community GP records to check whether he had been prescribed mirtazapine and this was never confirmed. Staff at Northumberland did not request his community records when Mr Lines arrived there. Mr Lines asked several times for antidepressants at Northumberland but they were not prescribed until 17 September and Mr Lines never received any before his death. We make the following recommendation:

The Heads of Healthcare at Durham and Northumberland should ensure that staff request and obtain community GP records in accordance with PSO 3050 to help effective continuity of healthcare.

Staff observations on 18 September.

64. While it is not possible to be accurate about the time of death, the pathologist and the GP both considered that the presence of rigor mortis and blood pooling in his lower limbs suggested that Mr Lines had died several hours before Officer A found him dead shortly after 9.00am. The night patrol officer checked Mr Lines at 6.52am. He said he was in bed at the time but did not record this in the ACCT document. Because of the advanced rigor mortis, there must be some doubt whether his recollection was correct.
65. At 7.53am, Officer A said that Mr Lines was standing with his back to the cell door, looking out of the window. He believed that Mr Lines had said something to him but could not be certain about this. He said he would not have moved on unless he had got a response, but it is evident that Mr Lines must have been dead at that time.
66. Officer A looked through Mr Lines' observation panel again at 9.00am and again considered he looked alive. He did not consider that anything was wrong, even

though Mr Lines was in the same position as over an hour earlier and he did not see him move. He did not try to speak to Mr Lines until he went back to have a conversation with him shortly afterwards. He then went into the cell and realised that he had hanged himself.

67. Although we cannot be sure what time Mr Lines died, the evidence suggests that he had been dead for some hours at 9.00am. We are not satisfied that checks that morning were sufficiently thorough – particularly as Mr Lines had been identified as at risk of suicide and self-harm. We make the following recommendation:

The Director should ensure that staff obtain a response from prisoners if they cannot establish that the prisoner is alive and breathing during roll checks, welfare checks, or ACCT checks.

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